‘Waiting in the wings’;
Lived experience at the threshold of clinical practice

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Context:

The transition to clinical practice is challenging. Lack of preparedness and issues with support, responsibility and complex workplace interactions contribute to the difficulties encountered. The first year of clinical practice is associated with negative consequences to new doctors’ health and wellbeing. The contemporaneous lived experience of new graduates on the threshold of clinical practice has not been described. Deeper understanding of this phase may inform interventions to ease the transition from student to doctor.

Methods:

We used Interpretative Phenomenological Analysis (IPA) to explore the individual experience of making the transition from medical student to doctor, focussing on the period prior to commencing clinical practice. Fourteen recent graduates were purposively recruited, and semi-structured interviews were conducted with each, with respect to how they anticipated the transition.

Results:

We draw on the metaphor of the actor ‘waiting in the wings’ to describe participants’ lived experience on the threshold of practice. The experience of the actor, about to step into the spotlight, was mirrored in participants’ perceptions of an abrupt transformation to come, mixed feelings about what lay ahead, and the various strategies that they planned to help them to perform their new role convincingly.

Discussion:

Participants in this study braced themselves for a trial by ordeal as they contemplated commencing clinical practice. The hidden curriculum shaped their understanding of what was expected of them as new doctors, and inspired dysfunctional strategies to meet expectations. Solutions to make the experience a more positive one lie in the approximation of the roles of senior medical student and newly qualified doctor, in explicitly addressing the hidden curriculum and generating

cultural change. An emphasis on experience based learning through contribution to patient care, guided reflection on the hidden curriculum, and shifting cultural expectations through faculty development and strong local leadership can contribute to these objectives.

Introduction

Transitions in medical education have been defined as 'dynamic movement across different expectations, tasks and responsibilities' (1, 2). Medical graduates find the transition from medical student to practising doctor a formidable one (3-7). Indeed, the first year of clinical practice has a negative impact on the mental health and wellbeing of doctors, with high rates of depression, anxiety, stress and burnout (8-12). Long working hours, high work intensity, issues with support, and difficult workplace interactions contribute to the challenges faced. Even before commencing work, graduates can feel intimidated in anticipation of the responsibility to be assumed, uncertain about what is expected of them and unprepared for certain aspects of practice (5, 13-18).

Expectations prior to transitions are important. A newcomer to an organisation may experience 'reality shock', due to a disparity between anticipation and actual experience. Expectations of the job, or, of their performance or emotional reactions to it, may diverge from the reality encountered (19). In the case of medical students, competencies they considered unimportant in medical school can assume great significance on commencing work (20-22). Lack of preparedness can cause anxiety and a fear of negative consequences for those in their first year of clinical practice (23). Graduates have high expectations of the standard at which they should perform. Failure to meet these standards can be distressing (16, 17, 24). They may also lack awareness of the pervasive nature of professional stressors in medicine, wrongly blaming themselves for perceived inadequacy on commencing practice (22). Furthermore, uncertainty regarding others' expectations of them in the workplace can result in a reluctance to seek help, due to a fear of negative scrutiny (15).

Much of our understanding about how the transition is experienced is based on opinions and attitudes of residents looking back at the transition to clinical practice. Less emphasis in the literature has been placed on exploring the experience of medical students and recent graduates as they contemplate the transition (4, 14, 25-27). Studies that have focused on competence and preparedness have provided us with some appreciation of the student perspective (5, 28-30). Additional insights

have been garnered from research into interventions aimed at easing the transition. These studies have revealed some concerns regarding lack of preparedness, and issues relating to responsibility, support, and workplace relationships (31, 32). A more comprehensive exploration of the experience of graduates as they anticipate commencing work would deepen our understanding of this very important time in the professional development of doctors and could help medical educators to provide targeted support to ease the transition.

The aim of this study was to address this gap by providing an in-depth analysis of the lived experience of medical graduates as they anticipate the transition to clinical practice. This study is part of a larger project that is a longitudinal exploration of the experience of transition to clinical practice from prior to practice through the first year of being a doctor.

Methodology

This study was conducted within an interpretative paradigm, using Interpretative Phenomenological Analysis (IPA) as a methodological approach. The three major theoretical underpinnings of IPA are phenomenology, hermeneutics and idiography (33). Phenomenology is a philosophical tradition concerned with the study of experience, as perceived by the individual. IPA is inspired by modern phenomenological philosophers such as Husserl, Heiddeger, Merleau Ponty and Sartre. Modern phenomenology was initiated by Edmund Husserl at the beginning of the 20th century. He advocated transcending preconceptions to identify the essence of a phenomenon, focusing on perception and consciousness. Heidegger and others however, argued that the individual should be viewed as 'embodied, embedded and immersed in a particular historical social and cultural context'. Because of this connectedness with the world, these phenomenologists, in the existential tradition, were more interested in describing and interpreting how individuals make meaning for themselves in the world they find themselves in (33-36).

Access to participants' 'meaning making', is dependent on the account provided by them, which researchers attempt to understand. This leads us to hermeneutics. IPA encompasses an interpretative undertaking, in that, as researchers, we interpret the account of how participants have in turn, interpreted their experience (the 'double hermeneutic'). IPA aims to understand what an experience is like from the point of view of participants, but also asks critical questions about the way participants have interpreted their experiences. (37). This may result in meaningful insights and a perspective beyond that offered by the participant (33-36).

The third theoretical underpinning of IPA is its idiography, a focus on the detailed exploration of the particular. The perspective of each individual is explored in full prior to moving onto the next case. Similarities and differences between cases can be appreciated after detailed exploration of the idiographic (33).

IPA is particularly concerned with experiences of significance to the individual, experiences that generate much cerebral and emotional activity, as individuals attempt to make sense of them (38). As the focus of this study is an exploration of the experience of transition to clinical practice from the perspective of medical graduates, IPA is an appropriate approach to use.

Context

This study was carried out in Ireland, in the Southern Intern Training Network, one of six networks nationally with responsibility for the first year of postgraduate medical training. Each network is linked to a medical school. Undergraduate medical education in Ireland is between 4 and 6 years in duration. Students can enter directly from second level education (high school) or may have a prior degree. Internship is a year-long period of transition from medical student to fully registered medical practitioner. It is analogous to the first year of the Foundation Programme (FY1) in the UK and to Postgraduate Year 1 in Australia (PGY1). In countries where there is no provisional registration phase, an intern is equivalent to a first year resident. As interns, doctors rotate through clinical posts, including a minimum of 3 months each in General Medicine and in General Surgery. They work under supervision, and on successful completion of the year can apply for specialist postgraduate training.

Participants in this study would expect to work in various affiliated hospitals and community settings in the Southern region. .

Ethical approval for this study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals, Ireland. NC, POL and DB are medical doctors with roles in the undergraduate medical programme linked to the Southern Intern Training Network. POL also has a role in the Intern Training Network. NC, who had no oversight of participants as interns, undertook all recruitment and interviews. These were anonymised prior to analysis by the rest of the research team. Pseudonyms were used in the reporting of results. The potential need for intervention or support regarding the wellbeing of participants was considered by the research team during data collection, however no such intervention was required.

Recruitment

Thirty–five recent graduates who were due to start their first year of clinical practice were contacted via email regarding the project. Recruitment was purposive, to ensure a gender balanced group and diversity of undergraduate medical programme experience. Written information regarding the study was provided and participants gave informed consent prior to engaging in the semi-structured interviews. Participants were assured that participation was absolutely voluntary and that they were free to withdraw at any stage.

Data collection

A pilot focus group was conducted with a group of outgoing interns to inform the semi-structured interview schedule, which was underpinned by principles of IPA (see appendix 1). NC conducted individual semi-structured interviews with each participant which were held in the 2 weeks prior to the commencement of clinical practice. All interviews were audio-recorded, transcribed verbatim and anonymised.

Data Analysis

NC and DB conducted the initial data analysis. Each transcript was analysed fully using IPA, prior to moving on to the next one (33, 34). Analysis commenced with immersion and familiarisation with the data through both listening, and reading and re-reading of the interview transcripts. In a first round of coding chunks of data were assigned summary descriptors which were meaningful in respect of the focus of the research. Following this, experiential themes, recurrent experiential assertions, were identified, each illustrated with verbatim extracts of text. Nvivo software was used as a data management tool (39). NC, DB and POL met regularly throughout the analysis to discuss identified themes, which were grouped into clusters of themes addressing related issues, known as superordinate themes. Once all transcripts were analysed, integration of themes across the entire dataset was undertaken. Both commonality and divergence were noted. An audit trail with clear documentation of each stage of the process was maintained for the duration of the study.

Reflexivity

The methodological approach employed necessitates an acknowledgement of the role of the researcher in the co-construction of knowledge with the participants. As such, we recognise the potential influence of the interviewer on the contribution of the interviewee, and of our own prior experiences, assumptions and preconceptions in shaping the outcomes of the study. As faculty from the same medical school as most of the participants we were conscious of our positionality, and engaged in 'critical self awareness' throughout avoiding assumptions of shared understandings or perspectives with participants, and prioritising the participants voice (40, 41). We supported each others' reflexivity and maintained reflexive diaries throughout the process.

Results

Fourteen participants were recruited. All participants, six males and eight females, were graduates of Irish medical schools. Four held prior degrees and had studied medicine in a medical course specifically tailored for graduates, the remainder had commenced their medical degrees directly from high school. Twelve of the participants had attended the local university aligned with the Southern Intern Training Network. Interviews ranged between 32min 2 secs and 70 mins 48secs duration.

We draw on the metaphor of the actor 'waiting in the wings' as an effective means to capture the totality of the experience of the medical graduate on the threshold of commencing practice. Metaphor is commonly used in reporting qualitative research (42). In this case, the metaphor was chosen as we discussed superordinate themes reflected in participants' accounts. The experience of the actor, about to step into the spotlight, is mirrored in the superordinate themes identified as participants made sense of this critical period; themes of abrupt transformation, mixed feelings and strategic planning. There were no significant themes in the data that diverged from this metaphor. Figure 1 shows the superordinate themes identified and their sub-themes.

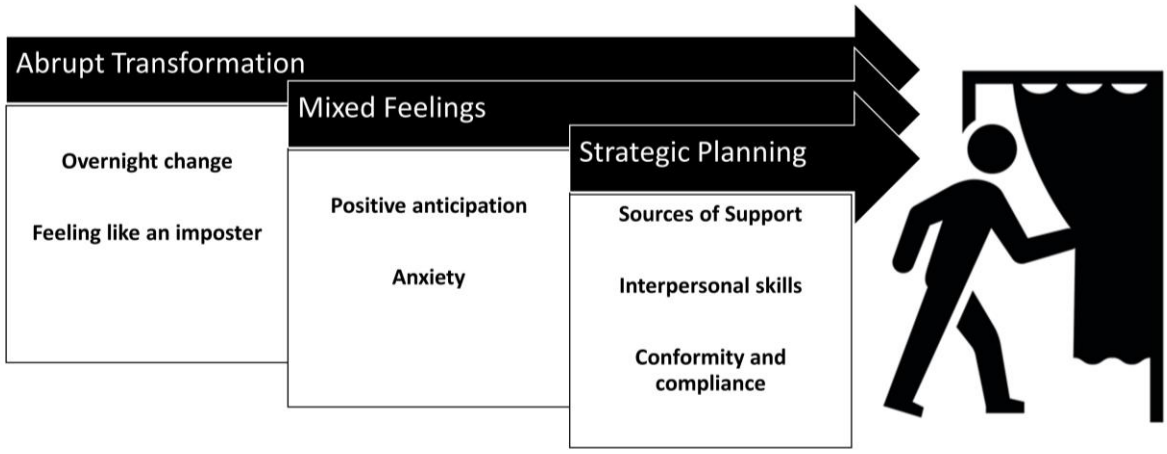

Figure 1. Superordinate and sub-themes

Abrupt transformation:

This theme included subthemes of ***'overnight change'*** and ***'feeling like an imposter'***.

Overnight change

Like an actor stepping onto a stage, most participants anticipated an abrupt transformation, from a position of invisibility and marginalisation as a student, to greater integration, participation, status and visibility.

> *'I can't wait to actually have a purpose, and a team as well, because as a student most of the time you are just following teams around, most of the time they don't want you there, you're being ignored a lot of the time'* ***Deirdre***
>
> ***'****It's going to be a big change, it's going to be a shock to the system, …. it's not like medical school …you have a job to do and it's up to you to do it, just a bit of responsibility that we haven't had before I guess'* ***Eugene***

Feeling like an imposter

Just as the actor wishes to convey their character with authenticity, participants worried about how they would inhabit their role, some feeling that they would not actually feel like a doctor at all in the early transition.

> *'It's very strange to think of myself as a doctor, …… I'll probably feel like an imposter for a little while'* ***Brian***

Mixed Feelings:

Waiting in the wings, the actor experiences mixed emotions. After long hours of rehearsals, they eagerly anticipate their moment to perform; however, they are also

apprehensive. This theme included subthemes of '***positive anticipation'*** and ***'anxiety'***.

Positive anticipation

Most participants expressed excitement at the prospect of commencing work. They were relieved at having completed the arduous undergraduate phase, and were looking forward to moving on to the next stage of their professional development.

> *'I'm really excited because I have been looking forward to this for so long'* ***Irene***
>
> *'My main thing would be the excitement, to be finally, … it was a long slog… so it's good to be moving onto the next phase'* ***Mark***

Anxiety

Mixed with these positive thoughts, and in some cases dominating them, was anxiety regarding the uncertainty and unpredictability of what lay ahead. In particular, assuming responsibility, and their anticipated feelings of fear and stress, as well as the isolation of nights on call, were sources of concern.

> *'So I am definitely anxious going into it anyway, there's a kind of a big element of not really knowing what to expect, or how well you are going to perform,'* ***Lucy***
>
> '*Definitely heading into my first medical call I will be quite anxious. It just feels like a lot of responsibility*..' **Gerard**

Most participants worried about their own performance, of not measuring up or that their mistakes might harm patients.

'Obviously .. that I would hurt someone, or I would cause .. some damage, or that I would do something really stupid or .. something …. that would be obvious to everyone else, but I just make a silly mistake.' ***Andrew***

Gerard considered his performance in the complexity of the busy clinical environment.

'Even if I had all the clinical knowledge in the world I would probably still be under stress from the sheer volume and also the pace at which I would be required to do it.' ***Gerard***

Many also expressed concerns about the physical and emotional demands of their new jobs, with Andrew raising the potential of burnout.

'I presume we are going to be so tired, you know, so tired all the time' ***Karen***

'I would just be worried about feeling or becoming jaded.' ***Andrew***

Actors expose themselves the scrutiny of others. Participants, likewise, considered the scrutiny that awaited them. They wished to prove themselves worthy colleagues. A fear shared by most participants, was that their inexperience might compromise the efficiency of the team resulting in negative evaluation. This awareness of scrutiny by seniors contributed to ambiguous feelings regarding seeking support. While acknowledging they would need support, they expressed a reluctance to ask for it because of their desire to be judged as competent and in control.

> *'I would feel that you don't want them to know that you feel a bit inadequate or something, ……you don't want to burden your team or kind of make it look like you are not able for the job'* ***Jane***

In addition, some participants also expressed their anticipation and apprehension regarding potential conflict in the workplace.

> *'You'd be a bit worried about how you'd get on with certain consultants like, you know I suppose it's like anything, certain people have a reputation that precedes them'* ***Andrew***

Strategic planning:

An actor about to step on stage plans how to deliver the best possible performance. He/she is aware of other actors whose words and actions will influence his/her own performance. Likewise, participants strategised about how they would act with and react to the other players in the workplace. Subthemes identified under this theme were ***'sources of support'***, ***'interpersonal skills'*** and '***conformity and compliance'.***

Sources of support

Participants contemplated how they would access support, citing nursing colleagues, with their experience and close proximity on the wards, as potential first ports of call.

'They are the ones who are around the wards and we'll be leaning on them for whatever. If a patient is sick, I'm sure they'll be quicker to spot it than you are …. Especially at the beginning when you are taking your baby steps into the working world.' ***Eugene***

They also hoped that the solidarity of their intern colleagues and that the empathy of previous interns would provide additional support for them. The team structure was recognised as providing a defined 'chain of command', however all described the arbitrary nature of this support.

'I think that SHO's, especially new SHO's, .. they were just where we are, so they maybe understand, .. and would hopefully be willing to answer your calls. I also think as well, I think the interns will support each other.'* ***Claire***

'I think that will depend on the team…how willing they are to support you…I hope they are supportive ..but I don't know is it always there, I think it is very much team dependent' ***Deirdre***

(*Senior House Officer- post graduate year 2 and 3)

Interpersonal Skills

Participants expressed a desire to integrate well into their new workplace, recognising the benefit of good communication and interpersonal skills for a smoother transition experience.

'I want to get on with everyone you know, I think it will make everything smoother. Because if you are on call and you need to call someone you won't feel

as awkward being like 'sorry I'm calling you in the middle of the night' …. and I really want to get on with the nurses as well because of that fear the whole time.' ***Claire***

Many anticipated that, although their interactions with their nursing colleagues might not always be positive, it was important tactically to foster good relationships with them. They recognised the power of nurses as a group and expressed a desire not to get on their bad side, fearing negative consequences. Some felt it necessary to cultivate a self-effacing attitude in interactions with nurses.

'Erm, it's a bit daunting I'll be honest with you. I feel like there is nearly an obligation, …. not the word, 'buttering them up' isn't the right phrase but I … feel like I would like the nurses on my side because….. nurses are fantastic and I've great respect for them in every sense, but they can be quiet sharp and they can put you in your place.' ***Faye***

Conformity and Compliance

Participants expressed a determination to comply with all the potential demands of their workplace.

'I'm not sure if I'll have time for lunch everyday honestly… I haven't really thought about it, but if there is a day that I don't get lunch, I don't know what I'll do, I think I'll bring a couple of snack bars in my bag or something, ..Breaks weren't really a priority for me going into this' ***Hannah***

Considering the prospect of negative interactions, they did not anticipate challenging people who behaved in an unprofessional manner towards them, often citing their low position in the medical hierarchy. Instead, there was a suggestion that they

should toughen up and accept it. Jane worried about her own emotional reaction to negative interactions feeling that she ought to be able to withstand and tolerate it. Hannah expressed the divergent opinion that 'a stern word' may be of academic benefit and 'is not always a bad thing I suppose'.

I'd like to say that I'd stand my ground but I very much feel that I'm going to be on the lowest rung of the ladder so I do feel there will be compromise on my part I'd say to deal with situations like that.' ***Gerard***

'Yeah, I suppose that will probably be one of the things that worries me.., as I would be a bit sensitive … and it might upset me a bit, but I think I am just going to have to deal with it, that's part of just taking things on the chin and getting a bit of a hard skin about it, you know.. just take a moment when needed and then move on and say, look maybe they're having a bad day'. ***Jane***

Discussion

Principal findings

The metaphor of the actor waiting in the wings is used here to explore the phenomenon of the transition from medical student to doctor from the perspective of recent graduates about to commence practice. As actors await their cue, they contemplate their imminent performance, how they will perform the role, adapt to the new set, interact with other actors and with the audience. Participants in this study, likewise, deliberated over how they would inhabit the role of competent intern, perform in the complexity of the clinical setting, improvise in response to the behaviours of others, and impress a critical audience of peers, senior doctors and other healthcare professionals. We have provided an insight into their excitement, expectancy, doubts and uncertainty as they stand on the threshold of practice.

Transition Shock

Participants' anticipation of the transition as an abrupt change in role and responsibilities, and the apprehension they expressed at the thought of being suddenly thrust into the limelight in this way, echo the phenomenon of 'transition shock' described in newly graduated nurses (43, 44). 'Transition shock' is an intense period of adjustment, characterised by feelings of inadequacy, anxiety, stress and powerlessness resulting in physical and emotional exhaustion. An important contributory factor to this experience is a disparity between expectations of the contributions undergraduate students and recent graduates should make in the workplace (44). Theories of workplace learning espouse gradual and progressive participation in practice (45), and tell us that medical students become capable and trustworthy doctors by making meaningful contributions to patient care (46). Participants in this study had rehearsed the role of doctor, gone through the motions in simulated and authentic settings, and yet it is clear that they anticipated that the performance of the role would be qualitatively different to the rehearsal. For them, status and responsibility appeared to be the key differentiating aspects of being a doctor. Traditionally, in Ireland and the UK, undergraduate medical education has not provided students with many opportunities for the supported assumption of clinical responsibility (5). More recently, interventions such as sub-internships and assistantships, where a senior medical student assists 'a junior doctor and, under supervision, undertakes most of the duties of an F1 doctor', have been employed in an effort to bridge this training practice gap and ease the abrupt nature of the transition (47, 48). It appears that these interventions can improve students' self-assessed preparedness to undertake the tasks of a doctor (49, 50). It is less clear whether they offer an opportunity to feel the status and responsibility of being a doctor. Despite experiencing these types of interventions, participants in this study anticipated the transition as an overnight transformation.

The Hidden Curriculum

Medical culture exerts a significant socialising influence on medical students (51). The hidden curriculum has been defined as a '*set of influences that function at the*

level of organisational structure and culture including…, implicit rules to survive the institution, such as customs, rituals and taken for granted aspects' (52). This study revealed the impact of the hidden curriculum on the meaning that participants made of working in clinical environments, the transition to practice and their plans in response its challenges. On the negative side, what they had seen and heard as medical students led them to express apprehension about support, scrutiny, the liklihood of difficult relationships with staff and challenges to their health and wellbeing. They appeared to be bracing themselves for an experience to be endured rather than enjoyed. Participants' planned behaviour to cope with these challenges was often dysfunctional and driven by unspoken cultural expectations. These included not taking breaks or eating properly, not necessarily seeking help when it was needed, and accepting being the target of rude, aggressive and dismissive behaviour.

Haidet and Stein described some of the cultural premises implicit in the hidden curriculum; doctors must be perfect, uncertainty and complexity are to be avoided, outcomes are more important than processes (eg certain behaviours can be excused if the desired outcome is positive), medicine takes priority, and hierarchy is necessary (53). Discourses of competence dominate those of caring in medical education, and vulnerability is often equated with incompetence. These messages compel students to prove their suitability for the profession by presenting themselves as confident, competent and capable, and to hide self-doubt or vulnerability (54-56). This can manifest as high personal expectations, and concerns about competence and adequacy, which exacerbate the stress of the transition, consistent with the feelings expressed by participants in this study (15, 57, 58). It also results in a reluctance to approach senior doctors for support (59), with potential risks to patient safety as a result.

The hidden curriculum contributes to a stigma towards doctors with mental health problems. Resonating with our participants' experience, previous studies have revealed a reluctance among trainees to admit to feeling overwhelmed, or to access support services, for fear of professional repercussions (60, 61). Participants were determined to comply with all the potential demands of the job including long hours

and high work intensity. Even prior to commencing work, participants appeared to prioritise the implicit message of 'unwavering duty' and to 'soldier on' above self-care and compassion (59, 62).

Participants, anticipating conflict in their new workplace, had already resolved to endure and accept it. Bullying, intimidation and harrassment often starts in medical school (52, 63, 64). Teaching by humiliation is one of the main ways that students learn about the importance of the medical hierarchy (52). The hidden curriculum cultivates a tolerance of bad behaviour in the clinical setting (65). Although provoking feelings of despair and hopelessness among students, a common response is to remain impassive and expressionless (66). They may excuse unprofessional behaviour of senior doctors, instead implicating external factors such as workload or fatigue or they may blame themselves for it (52). These attitudes are reflected in the pre-emptive rationalisation of bad behaviour observed in this study. Bullying, intimidation, and harrassment are endemic in postgraduate training and appear to be accepted as part of the workplace culture. These behaviours continue to be under-reported with trainees fearing personal and professional consequences (60, 67, 68). There is a danger that this behaviour, may in turn, be imitated by trainees, through their unconscious acquisition of the bad behaviour of their role models (69).

Support

More positively, participants did anticipate some supportive elements in the workplace. They identified their peers or their nursing colleagues as initial ports of call for assistance. They anticipated that their nursing colleagues would be available on the wards for uncritical advice and orientation, a perception borne out in the workplace (70). Their identification of the team structure for support and reassurance is consistent with evidence of its positive impact on wellbeing and sense of preparedness in the first year of practice (14, 25, 71). Participants intended to strategically foster good relationships with their colleagues to smooth their integration into the workplace. The intention to engineer a good relationship with their nursing colleagues for fear of the consequences of annoying or provoking them, and the perception that support from nurses can be variable (4, 14) suggests

that participants understood that interprofessional working relationships might be problematic.

Implications for practice

Our findings have highlighted areas where there is scope to improve the experience of transitioning to practice. Firstly, they reinforce the need to strengthen experience-based learning (46), so that the role of senior medical student approximates the role of newly qualified doctor, particularly in terms of status and responsibility. Medical students need to assume clinical responsibility incrementally over time so that the transition to practice becomes just another step in a series of small steps, and any risk of transition-shock is diminished. This approach would also allow students to develop and maintain more realistic expectations of themselves that are grounded in clinical experience. Greater integration within the clinical team structure, and for longer periods, (48) should facilitate both the development of status, and entrustment with responsibility for patient care. A workplace learning pedagogy for undergraduate medicine, such as Experience Based Learning (ExBL) may present a solution (46).

Secondly, the negative influence of the hidden curriculum should be challenged explicitly in an effort to avoid new doctors adopting behaviours that compromise their own wellbeing, as well as patient safety. Guided reflection by medical students to promote identification and critical evaluation of the hidden curriculum and of professionalism can empower students to become active participants in their own professional identity formation (69, 72-74) and to become agents of change in the workplace (75).

Cultural change is needed to create environments where new doctors can expect be treated respectfully, given appropriate support and not to feel pressure to conform to the notion of the 'perfect doctor'. Such change requires a multi-faceted approach and strong leadership to champion new approaches in daily practice. In addition to supporting newly qualified doctors to become agents for change as outlined above,

faculty development should support more senior staff to model and communicate appropriate professional behaviour (57, 69, 76-78). Supervisory approach, including clarity of communication, language used and creation of a safe and non-judgemental environment have been shown to encourage postgraduate trainees to seek support appropriately (79-81). Healthcare organisations must address issues within their own cultures to ensure that positive and supportive workplace relationships are fostered (82) along with the well-being of residents and faculty and the identification and remediation of problematic behaviour (76, 78).

Strengths and limitations

A strength of this study is that it captures in real time, the lived experience of anticipation of clinical practice from the perspective of the individual. This insight into the disposition and outlook of those facing the transition expands what we already know about the transition and can inform interventions at undergraduate and postgraduate levels. Nonetheless, there are limitations to our findings. Interviews were conducted by a member of medical school faculty who was known to many participants. Although the interviewer is not involved in the intern programme, it is possible that this participants' were not fully open in their accounts. Therefore, there may be dimensions of the experience that remained below the surface, yielding an incomplete understanding of the transition.

The majority of participants in this study attended the university aligned with the intern training network where they were about to commence work, which may be seen as a limitation in terms of wider applicability. It is our intention that conclusions drawn in the context of this study allow the reader to evaluate transferability to other similar settings.

Conclusions:

Waiting in the wings, on the threshold of clinical practice, participants in this study were bracing themselves for a trial by ordeal. The hidden curriculum shaped their understanding of what was expected of them as new doctors, and inspired

dysfunctional strategies to meet expectations. Solutions to make the experience a more positive one lie in the approximation of the roles of senior medical student and newly qualified doctor, in explicitly addressing the hidden curriculum and generating cultural change. An emphasis on experience based learning through contribution to patient care, guided reflection on the hidden curriculum and shifting cultural expectations through faculty development and strong local leadership can contribute to these objectives.

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